PERCEPTIONS OF ROLE BY MEDEX PHYSICIAN'S ASSISTANTS: AN INTERVIEW STUDY*

PAUL E. BREER, Ph.D., EUGENE C. NELSON, M.P.H., and IVY E. BOSSON

Department of Community Medicine
Dartmouth Medical School
Hanover, N.H.

MEDEX-New England is one of more than 150 programs in the United States presently training physician extenders.[1] Like the other eight widely distributed MEDEX programs, the one located in New Hampshire draws its applicants primarily from the pool of discharged military medical corpsmen. Trainees spend three months at the Dartmouth Medical School, where they receive intensive instruction with emphasis on history-taking and on the performance of physical examination. When this phase is completed, the Medex spends nine months (12 months for the first Medex class) working with a physican who assumes the role of teacher or preceptor. Ideally, at the end of the field training the Medex is hired as a full-time member of the practice staff. In this way it is hoped that the MEDEX program will contribute to relieving the shortage of primary health-care providers.

The MEDEX-New England program is being evaluated by a research staff which is independent of the training staff. Reports already published or submitted for publication include a survey of patients' attitudes toward Medex (highly favorable);[2] a study of how physicians perceive their Medex (very helpful in a variety of ways);[3] and an analysis of the impact of Medex on contacts with patients (37% increase in contacts two years after Medex are employed in practices).[4] Taken collectively, these studies would seem to indicate that the Medex program is a success, both in terms of acceptance by patients and physicians and from the viewpoint of making ambulatory care accessible to more people.

What is still missing is some indication of how the Medex them-

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selves feel about their new roles. It would be premature to assert that the program is working if the Medex were experiencing severe problems and are unduly dissatisfied with their activities. It is not unrealistic to assume that the addition of a Medex to an ongoing practice may generate stress—perhaps for everyone, but especially for the Medex himself. Possible areas of stress are status rivalries with the office nurse, protests from patients who refuse to see anyone but the physician, rejection by physicians in the area or by the local hospital staff, social rejection by the physician and his wife, and assignment of too little or too much responsibility.

Whether or not any of these represents a real problem for a given Medex or for a whole class of Medex is extremely difficult to assess without asking the Medex directly. The purpose of this study was to identify problems confronting the Medex in his relations with physicians, nurses, patients, and the community, including the hospital. It is assumed that once such problem areas have been identified, something can be done about them. Changes could be made, for example, in the way Medex are trained, in the types of practice they are sent to, or in the kinds of applicants accepted for training.

Since material of this sort is impossible to obtain in a self-administered questionnaire, personal interviews were used. The major drawbacks to this method (time and money) were not critical here because of the small number of Medex in the sample. To be sure that the Medex had been in the field long enough to have experienced a wide variety of problems, it was decided to limit the study to graduates of the first class of Medex-New England. At the time of the interview these Medex, all male ex-servicemen, had been in the field for two years after the completion of their training (three months at Dartmouth and 12 months with a preceptor). Of the 22 graduates, 17 were interviewed for this study. One could not be located. The last four on the list were omitted on the assumption that little new information would be forthcoming since they are still with their original perceptors.

Of the 17 who were interviewed, only eight are still with their original preceptor-physicians. Five are with their second physician, and another three are serving as Medex with their third physician. One is now a full-time college student and hopes to go to medical school. All persons interviewed were offered a small financial inducement to cooperate. The interviews, conducted by a specially trained inter-

viewer, lasted up to five hours and were characterized by warmth and candor. This is true even of the interviews with the four Medex who had moved to other parts of the country and who were interviewed over the telephone.

The reader should bear in mind that the material which follows is based solely on the perceptions of Medex physician's assistants and not on the perceptions of other important members of the role-set such as physicians, nurses, and patients.

Overview

Specific role problems are related to the Medex' over-all position in the practice organization. According to the philosophy of the trainers, the Medex is supposed to function as an assistant to the physician; he is definitely *not* meant to function as a physician. The major emphasis throughout the training at Dartmouth is on the development of expertise in taking histories and performing physical examinations. While it is assumed that in the field the Medex will "achieve competence in a wide diversity of activities,"[5] he is specifically not expected to exercise clinical judgment or to engage in differential diagnosis. These belong to the special universe of the physician.

In practice, some Medex appear to be serving exclusively as physician's assistants, much as the model prescribes; others just as clearly have moved beyond the model and are functioning more like physicians. Typical of the former is a Medex from a group practice in northern New England, who reports that he spends much of his time in performing routine physical examinations and in seeing patients who have minor problems. He sees most of the unscheduled patients; this enables them to be seen at once without interfering with the physician's schedule of appointments. The Medex does not, however, implement any therapy or prescribe any medication without first checking with one of the physicians in the group. Routinely, the Medex examines the patient and then waits in the hall for the physician. The Medex gives the physician his impressions of what is wrong and the physician tells him what treatment to administer. When making a house call, the Medex follows the same basic procedure—calling in his findings and receiving instructions from one of the physicians.

As delineated in the model, the Medex makes no diagnosis himself. He confines his activities rather to the collection of data and routine

treatments, which are given only after he has received specific instructions. The system seems to work well—physicians make more effective use of their own time and patients are treated more efficiently. Although the Medex sometimes becomes irritated at having to wait too long to confer with a physician, he is basically happy with the arrangements, since he had more responsibility than he felt comfortable with in the service.

At the other extreme, another Medex, who works for a nongovernmental medical service, operates a satellite clinic on an Indian reservation where he personally screens and treats 30 to 45 patients a day. The Medex represents the highest level of medical care available on a daily basis to the Indians in the area. Should any of the patients bring in a problem too difficult for the Medex and his staff, he communicates by radio either with another satellite clinic or with the medical center 100 miles away. If it is decided that the problem requires more expert, immediate attention, the patient is flown to the nearest Indian Health Service hospital, about 300 miles away.

Once a week a physician visits the clinic to see those patients the Medex feels should be rechecked by a physician. The physician also checks the charts of patients seen since his last visit. Even though he has two helpers who transport patients to the clinic, the Medex makes some house calls. Apparently he can speak enough of the dialect to communicate and he gets along well with the Indians. He even delivers some of their cows and horses, a service much appreciated by residents of the reservation.

The situation is without question unique. Though in this case the Medex is not actually employed by the Indian Health Service, he is functioning in a manner analogous to what the Indian Health Service calls a community health medic. The model, in this case, is much more nearly that of a physician; it is stated, in fact, that a community health medic will serve as a general practitioner "providing round the clock basic health services in areas where such services are not now available."[6] In this case there is little distinction between the special universe of the physician and that of the physician's assistant. The physician's assistant takes histories and performs physical examinations, exercises clinical judgment, makes diagnoses, and implements treatment, much as a physician would. The major difference is that the physician's assistant is still partly dependent for supervision and advice in his

practice on a physician who is based in a distant medical center.

The majority of Medex appear to be functioning at a level somewhat less autonomous than that of the Medex on the Indian reservation, yet more independent than that of the first Medex cited from northern New England. Typically, in the office the Medex takes histories and performs physical examinations; he does triage, screening, examinations of healthy children, and care of traumas; he sees patients with routine problems such as upper respiratory infections on a walk-in basis—referring them to the physician if necessary; he does minor surgery, inhalation therapy, and occasionally some laboratory work. In the hospital the Medex makes rounds and does admission and discharge studies. When he makes house calls, it is usually to elderly, chronically ill patients who cannot come to the office. Occasionally a Medex will deliver a baby. In some practices the Medex is allowed to formulate preliminary diagnoses and to write prescriptions which are then countersigned by the physician. Most Medex are on call at some time and handle a wide variety of problems by telephone.

Role Relations

Physicians. The specific relations that Medex have developed with their physicians are varied. In some practices the Medex is treated pretty much as an employee. One Medex, for example, spends a great deal of time in the hospital where he has much responsibility but sees very little of the physician. As the Medex perceives it, he works for the physician but not with him. He is there essentially to provide on-call relief for the physician, who is very busy. Although people at the hospital feel that he has done much to improve the quality of care in town, he is not included on the hospital staff nor is he allowed to attend any of the staff meetings. Outside of an occasional office party, the Medex never sees his physician-employer socially—"The last time we went out to dinner was at my interview." While grateful for all that his preceptor has taught him, the Medex feels that they are not personally close.

A second Medex, on the other hand, not only works closely with his doctor, he also lives with him. The physician is young and informal. The relation is obviously built on mutual respect and trust. "When I first started," the Medex said, "a man came in with a chain-saw injury to his foot; the front part was just barely connected to the rest and

I sewed it up with Tom (fictitious name for the physician) assisting and the foot is fine today." The Medex had had extensive experience in minor surgery and trauma in the military and enjoys this type of work. The physician is an internist and asks the Medex' advice when he has to do any suturing.

Medex report relatively little conflict with their physicians. They usually feel free to disagree and they discuss their disagreements openly with the doctors. One Medex said, however, that because he is not a physician the doctor must know better than he; for that reason, he never speaks up. Several others said that although they occasionally felt the physician to be wrong, they did not feel that it was their place to say so. The only reported incident in which a Medex became vocally angry with his physician involved an argument over financial arrangements.

The difference in status between Medex and physicians is felt keenly in some practices; in others it is hardly noticeable. Some physicians have their own circle of friends and the Medex is simply not included; or the Medex may be included but feels awkward and out of place. More typically, there is a periodic visiting back and forth between the two families. Once in a while it goes beyond this, as in the case of the Medex and the doctor who are hunting companions and whose families baby sit for each other during vacations. In another case, the physician went out of his way to include the Medex in all his social activities, made certain that the Medex was introduced to everyone in the medical community, and even arranged a loan so that the Medex and his wife could buy a second automobile to enable the wife to work in another community. For a time the Medex relied exclusively on his preceptor for friends, but has since branched out and joined a circle of younger persons with whom he feels more comfortable; nevertheless, he and the doctor still see each other socially every few weeks.

Other physicians in the community. Perhaps it is to be expected that not all the physicians with whom the Medex has contact will accept his role as legitimate. There is certainly evidence in the literature of deep-seated antipathy on the part of some physicians to the concept of the physician's assistant in any form.[7, 8] There is also evidence to suggest that much of the original hostility toward physician's assistants evaporates when they are observed going about their daily routine.[9] With few exceptions, the interviews substantiate the latter finding. As is usual-

ly the case, however, the exceptions are more interesting than the rule. In one case, the chief of the hospital staff is adamantly opposed to the whole concept of the physician's assistant and, although he likes the Medex, does not believe that anyone but a physician should attend patients. The same hospital has decided that every patient the Medex sees in the outpatient department must also be seen by his physician even though the Medex sees many patients independently at the office. In another setting, a Medex is prevented by a hospital staff from doing anything in the hospital, yet the same Medex has excellent relations with the staff at another nearby hospital.

Nurses. The nurse-Medex relation represents a potential source of conflict. For example, who is to take orders from whom? According to one report, the American Nurses Association declares that "nurses do not consider it legal or ethical to take orders from physician's assistants."[10] Yet the American Medical Association suggests that "the PA is the agent of the physician and therefore the nurse is actually taking orders from the doctor himself."[11] And then too there is the question of equity in salary. In New England the Medex, who are predominantly males, tend to be paid more than nurses even though the latter may have more formal education. According to the president of the American Nurses Association, "The exorbitant salaries that physician's assistants are being paid will tend to raise the price of health care to an even higher level."[12]

These are the ingredients of an explosive situation, yet the Medex (at least the 10 who have worked with nurses in the office setting) report little difficulty. In one practice the nurse had been with the doctor for more than 25 years and would not accept the introduction of the Medex. Consequently, she attempted to limit the contact of the Medex with the physician. The Medex soon left, for other reasons as well. Another elderly nurse could not adjust to a non-physician performing tasks that only the physician had done before. She and the Medex talked about it but nothing that was said helped her accept the idea of a physician assistant. She retired, perhaps to avoid the situation.

In another practice, the Medex reports having trouble with one of the nurses at the hospital. This Medex said the nurse was "very conscious of whether I was below or above her." Once he asked her to do something that his physician wanted done and she refused to take orders from him. When he explained that the orders were the doctor's and not

his, she complied. Ever since, he has been very careful to say "Dr. X would like you to do such and such," so that she does not think he is trying to act like a doctor himself.

More commonly, the problems reported appeared at the outset, when the nurse did not know what to expect and feared that a newcomer would usurp a portion of her privileges and responsibilities. Usually, the problem resolved itself as the Medex moved gingerly into his role and the nurse realized that her position was secure.

Patients. Physician assistants have been criticized by many and probably most vociferously by physicians themselves, not on their own behalf, but out of concern for patients. One physician, for example, has written in a medical journal, "Physicians may be losing their identity as only one group in the 'health professions,' but in the final analysis when a patient is sick he wants the doctor, not the nurse, not the technician, and surely not his non-M.D. assistant."[13] Yet in a study in which patients were systematically surveyed, the results were overwhelmingly positive. When asked whether they would want the Medex to participate in their care again, 83% said "definitely," another 16% said "probably"—leaving only 1% who said "no."[14]

There is no question that, as the Medex see it, they are clearly accepted by all but a small minority of their patients. Most typically, there was some resistance at the beginning, especially among patients who had known their doctors for many years. In most practices, all patients were given the option of being seen by the doctor if they wished. Some did so and continue to do so, almost three years later. Most patients, however, have come to accept whichever provider is available, unless the situation demands the physician's special skills. The result is that they usually are seen sooner. According to one Medex, "When patients call up and ask for an appointment with Dr. X and are told how long the wait is (three months), they are usually happy to see me instead. Some ask for me directly as well." Asking directly to see the Medex is common to many of the practices.

Many patients think of the Medex as the doctor; at least this is the way it appears to the Medex. All 17 who were interviewed said that they are called "Doctor" by at least some of their patients. Most have gone out of their way to explain that they are not physicians, but the practice persists. If the patients do not call him "Doctor," then it is usually "Mr." or his first name, but rarely "Medex X."

Like the physicians they serve, most Medex enjoy working with some kinds of patients more than with others. Some have indicated a preference for the chronically ill; others would rather perform minor surgery and treat traumas. Still others are most interested in psychiatric problems. The age of the patient may also make a difference. A Medex who spends much of his time in the hospital says he prefers to work with children, "especially since they're usually very scared of the hospital and I can help them to feel better about the whole trip."

Community. With very few exceptions, Medex are liked and respected by their communities. In unsophisticated rural villages they are treated as if they were doctors; in the towns and cities people tend to have a more realistic idea of who they are. Most of them have become involved in local activities and now find themselves quite visible members of the community. Two have become city health officers; another is the town's civil defense officer. Several are active in local sports, both as players and as referees. One has organized both a softball league and a snowmobile club. Others are involved in cancer drives and community health-education campaigns, as well as in fraternal and civic organizations. Another spends a part of each week in a community center where people can come when they need someone to talk to about drugs, personal problems, etc.

Not all Medex, however, are so well integrated into their communities. One Medex works in a very small, conservative, and economically depressed New England town where the older residents consider anyone not born and raised there to be a stranger. Because jobs are scarce, most of the young people leave town as soon as they graduate from high school. Consequently, the young Medex and his wife keep pretty much to themselves.

Satisfaction

Medex are generally contented. When asked what gave them the most satisfaction, over half answered "being able to help people in some way." Many mentioned specific incidents, such as recognizing appendicitis in an elderly patient after a doctor had treated him initially for a minor stomach ache and sent him home or counseling a couple and helping to save their marriage. One Medex who sees many elderly patients said he enjoyed seeing patients who he thought did not have a chance to live come back laughing and smiling. Another Medex found

being a pioneer in a new field exciting and satisfying. In a statement that probably speaks for the whole group, one Medex said, "I enjoy making a minimum number of mistakes while doing the maximum amount of work I am capable of and being recognized for such."

When pressed for sources of dissatisfaction, most Medex managed to offer a response. Two mentioned unfortunate experiences while making house calls—one was threatened with a gun and another was thrown out when he would not prescribe the medication the patient requested. Some cited specific medical procedures they did not like performing: e.g., treating fecal impaction and doing Pap smears. One Medex found it especially frustrating when patients did not seem to respond to perfectly sound treatment. Another found it difficult to speak to the relatives of elderly patients.

More frequently mentioned were the long hours, the paperwork, and salary. Just less than half of the Medex expressed dissatisfaction with what they were earning. Many felt that they could not comfortably support their families on what they were paid. Others contended that their salaries did not compensate them sufficiently for the long hours they put in and for the disruption of their personal lives that their duties entail.

The average starting salary for the 17 Medex in the sample was $10,000, with a range of approximately $8,000 to $12,500. By the time of the interview, two years later, the average had increased to $11,560, with a range of $9,200 to $14,000. This is lower than the national average for male physician's assistants with two years experience ($12,985).[15] None of these figures includes benefits, which range from none at all to comprehensive federal benefits, automobile payments, insurance premiums, and fees for continuing education courses.

Of those Medex who said they were dissatisfied with their salaries, about half (i.e., one quarter of the sample) indicated that they were seriously thinking about, or had already decided upon, seeking new positions. Nine of the 17 who were interviewed have left their original preceptor and are working for a second or third physician. In other words, there is much mobility from one practice to another. The reason most often given for leaving was a personality clash with the preceptor or, for a few, a lack of respect for the way the physician was practicing medicine.

Despite all the geographical mobility, most of the 17 Medex expected

to be still functioning as physician's assistants five years from now. A few reported frustration at the lack of opportunities for advancement—two were hoping to go through medical school—but the majority seemed grateful that the Medex program had evolved so that they could stay in the medical field without having to become orderlies, technicians, or nurses.

When asked how they felt about the future, several expressed concern that a physician might not want an older man as his assistant and that the retirement benefit program was inadequate. Yet neither of these constitutes an overriding concern. At present, the Medex as a group seem to be decidedly content with things and pleased that they have been chosen to help launch a new role.

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